

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN2601</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/16/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHERN TENN MEDICAL CENTER SNF</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>629 HOSPITAL ROAD WINCHESTER, TN 37398</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments  Investigation of complaint #TN00055716 was conducted on 11/15/2021-11/16/2021 at Southern Tenn Medical Center. No health deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE